Supreme Court, U.S.
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No.

In the Supreme Court of the United States

PHILIP H. SANDERSON,

Petitioner,

v.

HCA-THE HEALTHCARE COMPANY;
COLUMBIA HEALTH CARE CORPORATION;
HOSPITAL CORPORATION OF AMERICA;
and HEALTHTRUST INC.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the heightened pleadings requirement of Rule 9(b) requires a qui tam plaintiff to specifically describe more than the fraudulent accounting scheme underlying a series of continuous and ongoing false hospital cost reports which inflates the defendants' ongoing claims for reimbursement from the government?

2. Whether false claims submitted within the period of limitations, but based upon a fraudulent accounting scheme developed outside the limitations, but still in use, are time barred?

STATEMENT PURSUANT TO SUPREME COURT RULE 29.6

Petitioner, Philip H. Sanderson, is a private individual.

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OPINIONS BELOW

The ruling of the United States Court of Appeals for the Sixth Circuit dated May, 12, 2006 affirming the decisions of the District Court is officially reported at 447 F.3d 873 and is reproduced at App. A at 1a.

The decision of the United States District Court for the Middle District of Tennessee dated September 28, 2004 dismissing the Petitioner's Amended Complaint not reported and is reproduced at App. B at 12a.

JURISDICTION

The ruling of the United States Court of Appeals for the Sixth Circuit sought to be reviewed was entered on May, 12 2006. This petition is timely filed under 28 U.S.C. § 2101 and Supreme Court Rule 13.1 because it is being filed within 90 days of entry of the ruling sought to be reviewed. This Court has jurisdiction to review the ruling of the United States Court of Appeals for the Sixth Circuit pursuant to 28 U.S.C. § 1254.

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions of the False Claims Act, 31 U.S.C. §§ 3729, *et seq.* and Rule 9, Fed. R. Civ. P. are set out at App. C at 22a.

STATEMENT OF THE CASE

This is a False Claims Act case filed by the relator Philip H. Sanderson formerly an Assistant Vice President of HCA, on behalf of the United States of America against HCA and its predecessors over the falsification of cost reports the

Defendants and its predecessors submitted to the United States under the Medicare, Medicaid, CHAMPUS and Tricare programs that resulted in more than $200 million in overpayments to the Defendants and its predecessors.

The complaint was originally filed June 28, 2001. After the Government declined to intereve the Complaint was unsealed and served upon the Defendants. The Defendants moved to dismiss under Rule 9(b) asserting that the heightened pleading requirements were not satisfied and under 12(b)(6) asserting that the claims were time barred or that they failed to state a claim upon which relief could be granted.

The trial court granted the Petitioner leave to amend. Upon a renewed motion by the Respondent the trial court dismissed the amended complaint on the basis of the statute of limitation failure to comply with Rule 9(b), Fed. R. Civ. P. Alternatively, the trial court in dicta indicated that because the Petitioner failed to cite a regulation or rule which was violated that it would have determined that the complaint failed to state a claim upon which relief could be granted.

The United States Court of Appeals for the Sixth Circuit affirmed in an opinion issued May 12, 2006. The Court of Appeals based its decision upon Rule (9)(b), but nonetheless indicated in dicta that the trial court was correct in its determination that the claims were time barred and did not state a claim under Rule 12(b)(6).

A. Summary of the Allegations of the Amended Complaint

The Defendant and its predecessors are participants in the various Medicare and various other government run programs that provided for reimbursement for providing medical

services to persons who qualified under the various programs. The amended complaint sets out in detail the accounting scheme utilized by Defendant and its predecessors of assigning debt and the corresponding expense directly to various facilities within the hospital chain as opposed to allocating the debt through the home office as required under the Medicare Rules and Regulations. The net effect of this was that it increased the reimbursement rates to the Defendant and its predecessors each time that it submitted a request for reimbursement. Requests for reimbursement come in two forms, prospective and retrospective. The requests for retrospective reimbursement are submitted each time a patient is discharged from a facility, *i.e.* daily. The requests for prospective reimbursement are submitted once each year with the annual cost reports as part of the medicare program participation.

Beginning in or about 1981 and continuing the method resulted in false claims and overpayments annually in excess of 13 million dollars from Medicare to the Defendant and its predecessors.

Petitioner left the employ of the Defendant in 1989. Nonetheless the same accounting method was used for all debt that was still outstanding within the 6 years prior to the filing of the complaint. In addition, petitioner alleged, upon information and belief, that the same methodology was still in use for debt that was acquired after his departure from the Defendant, thus resulting in continuing false claims and continued overpayments.

B. The Decisions Below

The District Court held that the Amended Complaint failed to specifically allege instances of fraudulent conduct

occurring within the limitations period since the assignments of debt that were specifically detailed occurred outside the limitations period, despite the fact that claims are submitted on an ongoing basis and not all the debt was retired outside the limitations period. Although the Petitioner alleged upon information and belief that such conduct was continuing the District Court held that such was insufficient.

The District Court went on to further hold that Petitioner failed to describe in his First Amended Complaint any fraudulent claims made during the statutory period. App. B at 20a. "Moreover, Plaintiff has failed to identify any applicable rule or regulation that was violated by HCA since 1995. Because Plaintiff has not alleged sufficiently each element of his claims under the False Claims Act, it appears beyond doubt that the Plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Id.*

The Court of Appeals in affirming the District Court limited its holding to the sufficiency of the Amended Complaint under Rule 9(b). The Court of Appeals held that there was no specific information about the filing of the claims themselves-nothing, that is, to alert the defendants to the precise misconduct with which they are charged and to protect the defendants against spurious charges of immoral and fraudulent behavior. 447 F.3d at 877. Further, the Court of Appeals indicated that Petitioner failed to identify any claims submitted for payment. 447 F.3d at 879. Finally, the Court of Appeals indicated that the action was time barred, but did not discuss the matter in light of its ruling on the basis of Rule 9. *Id.*

REASONS FOR GRANTING THE PETITION

This case presents two important issues of federal law, first whether Rule 9(b) particularity requirements apply to the False Claims Act (and if so the extent of information that must be alleged with particularity) and secondly, whether the concept of continuing violations exist in the context of the False Claims Act when the fraudulent scheme is developed and implemented outside the period but forms the basis for claims made within the limitations period.

THE PARTICULARITY REQUIREMENTS UNDER RULE 9 ONLY INTENDED TO PROVIDE THE DEFENDANT WITH FAIR NOTICE

Various circuit courts that have extended Fed. R. Civ. P. 9(b) to False Claims Act with varying and inconsistent results as to what more than the plain statement required under Rule 8 was required of a *qui tam* plaintiff. The Fifth Circuit has indicate that, "[a]t a minimum, Rule 9(b) requires that the plaintiff specify the 'who, what, when, where, and how' of the alleged fraud." *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 903 (5th Cir. 1997). The Eleventh Circuit has indicated a qui tam plaintiff must allege "(1) precisely what statements were made in what documents or oral representations or what omissions were made, and (2) the time and place of each such statement and the person responsible for making (or in the case of omissions, not making) same, and (3) the content of such statements and the manner in which they misled the [government], and (4) what the defendants obtained as a consequence of the fraud." *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.*, 290 F.3d 1301, 1310 (11th Cir. 2002). The Sixth Circuit has indicated a plaintiff complying with the requirements of Rules 9(b) must allege the

time, place, and content of the alleged misrepresentation or fraud; the fraudulent scheme; the fraudulent intent of the defendant; and the injury resulting from the fraud. *United States ex rel. Bledsoe v. Community Health Systems, Inc.*, 342 F.3d 634, 643 (6th Cir. 2003).

By contrast, this Court has never extended or imposed such strict pleading requirements to False Claims Act complaints. In the context of a false claim based upon fraudulent accounting scheme that underlies the very structure of the cost accounting system in place by the Defendant, it hardly comports with the underlying purposes of Rule 9(b), providing the Defendant with fair notice of what is being claimed, to require the *qui tam* plaintiff to specifically plead information uniquely within the control and knowledge of the Defendant. Requiring that the specificity include, the time and place of each claim for reimbursement when such claims are submitted daily for the retrospective reimbursement and each year for prospective reimbursement would be the equivalent of requiring the qui tam plaintiff to carry his evidentiary burden in the pleadings stage.

The underlying function of the particularity requirements are to place the defendant on notice of what is being claimed. Since the very documentation is in the possession of the Defendants they are clearly put on notice when the fraudulent accounting scheme, methodology and use is identified. When Rule 9(b) is read in conjunction with Rule 8, it is clear nothing in Rule 9(b) requires the level of specificity imposed by the Sixth Circuit or any other circuit court having addressed it in the context of the False Claims Act. Rather, it provides that "[i]n all averments of fraud or mistake, the *circumstances* constituting fraud or mistake shall be stated with particularity." Had the drafters of the rules intended "circumstances" to mean each "fact" or the "who, what,

when, where, and how" constituting the fraud to be plead they could easily have chose such language. Rather, as this Court has recognized in the context of the securities statutes, the underlying purposes of the pleadings rules is to provide the defendant with notice of the offending conduct. *Dura Pharmaceuticals v. Broudo*, 544 U.S. 336, 346-347 (2005).

CLAIMS SUBMITTED WITHIN THE LIMITATIONS PERIOD CONSTITUTE VIOLATIONS OF THE FALSE CLAIMS ACT EVEN WHEN BASED UPON TIME BARRED ACTS

The original complaint was filed in this matter on June 28, 2001. Sanderson left the employment of the Defendants and their predecessors in 1989. The False Claims Act provides that an action may not be brought more than 6 years after the date on which the violation of section 31 U.S.C. § 3729 occurs. 31 U.S.C.§ 3731(b). The Court of Appeals as well as the District Court focused exclusively on the dates of the debt assignment and not the subsequent dates that the claims were submitted based upon the assignments. Debt is amortized over a number of years and the interest expense even though assigned in one year continues until such time as the debt is retired. While the initial decision to assign debt may be outside the limitations period, claims are still being submitted within the limitations period.[1]

A violation within the meaning of the statute occurs with each submission of a false claim. The acts the Court to focused upon were the original assignments of debt or the

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[1] The amended complaint also alleged that the methodology used to assign debt in violation of the Medicare Rules and Regulations continued even after the Petitioner left his employment.

decision of the Defendants to assign costs in such a fashion to violate the rules of the Medicare program, its reimbursement regulations and, in turn, the law. Such an interpretation has long ago been rejected because it is not the decision to violate the law and submit the false claim that triggers the limitations period, but the actual submission of the claim which constitutes the violation of the False Claims Act each submission of which constitutes a separate violation subjecting the Defendants to forfeiture and penalty. *United States v. Bornstein*, 423 U.S. 303, 312-13 (1976). It matters not when the initial scheme or pattern was adopted. Each subsequent claim for payment made by the Defendants which was based upon cost reports prepared and submitted to the government constitutes a separate violation. In this case, claims for payment are submitted on an ongoing basis. While the initial decision was made to assign debt in the future in a way that violates the rules and regulations of the program may have been made in the early 1980s, the assignment method continued with each new debt instrument and even the assignment of older debt instrument continued to result in inflated cost reports well into a period within limitations as the capital and debt costs were amortized. Until fully amortized and retired, such assigned debt affects the annual cost report and in turn each claim for reimbursement based upon the inflated costs reports.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

United States Court of Appeals
Sixth Circuit

No. 04-6342

[Filed May 12, 2006]

Philip H. SANDERSON, Plaintiff-Appellant,	)
v.	)
HCA-THE HEALTHCARE COMPANY; Columbia Health Care Corporation; Hospital Corporation of America; and HealthTrust Inc., Defendants-Appellees.	)

Before: DAUGHTREY and MOORE, Circuit Judges; ALDRICH, District Judge.*

DAUGHTREY, Circuit Judge.

In this False Claims Act suit, Philip Sanderson charged that the defendants, HCA-The Healthcare Company (now HCA, Inc.) and its corporate predecessors, Columbia Health

* The Honorable Ann Aldrich, United States District Judge for the Northern District of Ohio, sitting by designation.

Care Corporation, Hospital Corporation of America, and HealthTrust, Inc. (collectively "HCA"), had violated the Act by filing "hospital cost reports" based on the allocation of corporate debt expense to its individual facilities rather than to the "home office," a practice that Sanderson contends was in violation of Medicare and similar federal programs from which HCA was claiming reimbursement. The district court dismissed the complaint, holding that, as amended, it failed to meet the pleading standards for allegations of fraud under Federal Rule of Civil Procedure 9(b), that it failed to state a cause of action under Rule 12(b)(6), and that it was filed outside the applicable six-year statute of limitations. Because we conclude that the complaint was subject to dismissal for failure to conform to the requirements of Rule 9(b), we affirm the judgment of the district court. Having made that determination, we decline to address the remaining questions raised on appeal.

FACTUAL AND PROCEDURAL BACKGROUND

Sanderson was employed by HCA-one of the country's largest hospital chains-from 1975 to 1989, working as an auditor responsible for, among other things, reviewing cost reports, preparing budgets, and coordinating year-end audits by outside auditing firms.

On June 28, 2001, more than 11 years after he left HCA, Sanderson filed this *qui tam* action in the name of the United States, charging that the defendants had overcharged the government for reimbursements under the Medicare, Medicaid, and Civilian Health and Medical Program of the

Uniformed Services (CHAMPUS) programs.[1] Specifically, the plaintiff claimed as relator that the defendants had incurred millions of dollars of debt for construction purposes as part of a long-term acquisition and expansion project. Rather than claim this debt as an expense of the home office and submit it as an expense for federal reimbursement based on the weighted-average Medicare use rate of all HCA-owned hospitals, the plaintiff alleged, the defendant allocated this corporate debt among the individual hospitals based on the percentage of Medicare-eligible service the hospitals provided. In this way, the plaintiff claimed, the largest portions of the debt were included in the expenses of those hospitals that had the highest Medicare service rates, and HCA was thereby able to reap the greatest federal reimbursement possible.

The *qui tam* complaint included a handwritten "analysis of debt allocation" prepared by Sanderson that purported to reflect how several multi-million dollar debt issuances by HCA had been allocated among various hospitals for the years 1981-1986. The latest item on the list was dated August 21, 1986. The plaintiff also attached two internal memoranda written from one HCA official to another in 1981 and a third written in 1983 that discussed the debt allocation. These were the only specific dates and incidents included in the original complaint. However, following both a notice from the government that it was declining to intervene in the action and a motion to dismiss filed by HCA, the plaintiff amended the complaint, purportedly to "plead more particularly." Nevertheless, the amended complaint was virtually unchanged from the original, except that it offered a more detailed

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[1] The CHAMPUS program is now known as the TRICARE Management Activity.

explanation of the process by which the defendants allegedly overcharged the United States and claimed that "the defendants and their predecessors, upon information and belief either continued the direct assignment of debt or made a direct 'reassignment' of debt and corresponding debt expense to the same facilities or other facilities with greater utilization rates ...." The plaintiff's allegation that some of the various notes securing the company's construction debts were not due until 1996 and 1999 and that one set of debentures would come "due in 2016" set out the only dates in the amended complaint that fell within the statute of limitations.

The complaint did not refer to a specific fraudulent cost report or other claim filed with the government, nor did it detail who had filed such a claim or when it had been filed. The plaintiff, in a grammatically awkward allegation, asserted that the defendant's interest expense "*is* ongoing and continues until such time as the debt *was* fully retired, thereby resulting in continued overpayment until such time as the debt *was* fully paid or amortized. Thus, debt assigned in year one *would* result in an inflated cost report for the facility for as many as 20 or even 30 years into the future and *continues to this day*." There is, however, no allegation that the debentures are still outstanding, only that if not "fully paid or amortized," they would produce inflated debt expense.

The other component missing from the complaint is any identification of the "applicable laws and regulations" that purportedly required allocation of debt expense to the "home office."

The defendants moved to dismiss the complaint pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6) and the six-year statute of limitations in the False Claims Act, 31 U.S.C. § 3731(b)(1). The district court granted the motion on

all three grounds, finding that the plaintiff had failed "to set forth specific allegations of fraudulent conduct ... within six years of the filing date of this action." Specifically, the court held that the bare contention in the amended complaint that HCA's allegedly fraudulent conduct continued after 1995, based only upon "information and belief," was too "vague and cursory [to] rise to the heightened level of the requisite specificity under Rule 9(b)." The court also ruled that the complaint failed to state a claim upon which relief could be granted because the complaint "fails to describe ... any fraudulent claims made *during the statutory period*" or "identify any applicable rule or regulation that was violated by HCA since 1995." (Emphasis added.) This appeal ensued.

DISCUSSION

We review *de novo* a district court's dismissal of a complaint for failure to state a claim, including dismissal for failure to plead with particularity under Rule 9(b). *Yuhasz v. Brush Wellman, Inc.*, 341 F.3d 559, 563 (6th Cir.2003). In acting upon a motion to dismiss, a district court must accept as true the plaintiff's well-pleaded facts and draw all reasonable inferences in favor of the complaint. *Id.* Moreover, a complaint may not be dismissed "'unless it appears beyond doubt that plaintiff can prove no set of facts in support of his claim that would entitle him to relief.'" *Michaels Bldg. Co. v. Ameritrust Co., N.A.*, 848 F.2d 674, 679 (6th Cir.1988) (citing *Conley v. Gibson*, 355 U.S. 41, 45-6, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957)). However, when deciding a motion to dismiss under Rule 9(b) for failure to plead fraud with particularity, a court must also consider the policy favoring simplicity in pleading, codified in the "short and plain statement of the claim" requirement of Federal Rule of Civil Procedure 8. As we have noted, "Rule 9(b)'s particularity

requirement does not mute the general principles set out in Rule 8; rather, the two rules must be read in harmony." *Michaels Bldg. Co.*, 848 F.2d at 679. On the other hand, a district court need not accept claims that consist of no more than mere assertions and unsupported or unsupportable conclusions. *Kottmyer v. Maas*, 436 F.3d 684, 688 (6th Cir.2006).

The False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, makes illegal the submission of false or fraudulent claims to the federal government. The so-called "qui tam" provision in § 3730(b) authorizes private individuals to sue on behalf of the government in order to aid in ferreting out abuses, thereby "unleashing a posse of *ad hoc* deputies to uncover and prosecute frauds against the government." *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 784 (4th Cir.1999) (citations and internal quotation marks omitted). Originating during the Civil War in response to widespread fraud in wartime defense contracts, the Act has been repeatedly amended, representing "a long history of repeated congressional efforts to walk a fine line between encouraging whistle-blowing and discouraging opportunistic behavior." *United States ex rel. Karvelas v. Melrose-Wakefield Hospital*, 360 F.3d 220, 225 (1st Cir.2004) (internal citations and quotations omitted). The facts here suggest that opportunism rather than legitimate whistle-blowing motivated the filing of Sanderson's complaint.

Because the basis for a *qui tam* action is *fraud* in the filing of claims against the government, we have held, as have other circuit courts in False Claims Act cases, that allegations in the complaint must comply with the particularity requirements of Federal Rule of Civil Procedure 9(b). *Yuhasz*, 341 F.3d at 563; *see also Karvelas*, 360 F.3d at 228 (collecting cases). We have further interpreted Rule 9(b) to require that a

plaintiff "allege the time, place, and content of the alleged misrepresentations on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *Yuhasz,* 341 F.3d at 563 (quoting *Coffey v. Foamex L.P.,* 2 F.3d 157, 161-62 (6th Cir.1993)). As a sister circuit has phrased it, "[a]t a minimum, Rule 9(b) requires that the plaintiff specify the 'who, what, when, where, and how' of the alleged fraud." *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.,* 125 F.3d 899, 903 (5th Cir.1997) (citation omitted).

We conclude that the district court was correct in finding that Sanderson failed to allege a False Claims Act claim with sufficient particularity, as Rule 9(b) requires. The complaint sets out at some length a description of the accounting methodology used by HCA in allocating corporate debt, even identifying some of the specific loans undertaken by HCA and future dates on which the notes and debentures securing those loans came due. The plaintiff describes this accounting method as "prohibited" and asserts that any claims against the government for reimbursement of debt expenses resulting from the accounting method must necessarily violate the Act. Unfortunately for the plaintiff, there is no specific information about the filing of the claims themselves-nothing, that is, to alert the defendants "to the precise misconduct with which they are charged and [to] protect[ ] defendants against spurious charges of immoral and fraudulent behavior." *United States ex rel. Clausen v. Laboratory Corp. of America, Inc.,* 290 F.3d 1301, 1310 (11th Cir.2002) (quoting *Ziemba v. Cascade Int'l., Inc.,* 256 F.3d 1194, 1202 (11th Cir.2001)). As the Eleventh Circuit has held, in *qui tam* actions, the heightened pleading requirements of Rule 9(b) are met by a complaint that sets out:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and (2) the time and place of each such statement and the person responsible for making (or in the case of omissions, not making) same, and (3) the content of such statements and the manner in which they misled the [government], and (4) what the defendants obtained as a consequence of the fraud.

Id. Here, as in the Eleventh Circuit's *Clausen* case, the plaintiff's complaint "does not identify any specific claims that were submitted to the United States or identify the dates on which those claims were presented to the government and relies [instead] exclusively on conclusory allegations of fraudulent billing." *Id.* at 1311 (citations omitted). But, as the *Clausen* opinion notes, "[t]he False Claims Act does not create liability merely for a health care provider's disregard of Government regulations or improper internal policies unless, as a result of such acts, the provider knowingly asks the Government to pay amounts it does not owe." *Id.* As a result, Rule 9(b) "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply ... that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." *Id.*

Like the fraudulent scheme in *Clausen,* the accounting method at the heart of the allegation of fraud in this case is likewise not a violation of the Act, "because the statute attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the 'claim for payment.'" *United States v. Rivera,* 55 F.3d 703, 709 (1st Cir.1995). *See also Thompson,* 125 F.3d at 902 (claims for services rendered in violation of a statute do not necessarily constitute false or fraudulent claims under the FCA); *United*

States ex rel. Hopper v. Anton, 91 F.3d 1261, 1266 (9th Cir.1996) ("Violations of laws, rules, or regulations alone do not create a cause of action under the FCA."). Thus, as the court noted in *Clausen,* the fraudulent claim is "the *sine qua non* of a False Claims Act violation." 290 F.3d at 1311.

As to the claims in this case, however, we have only the allegation that to the plaintiff's "information and belief," fraudulent claims have been made based on HCA's allegedly illegal accounting methodology. And although courts have permitted allegations of fraud based upon "information and belief," the complaint "must set forth a factual basis for such belief," and the allowance of "this exception 'must not be mistaken for license to base claims of fraud on speculation and conclusory allegations.'" *Thompson,* 125 F.3d at 903 (quoting *Tuchman v. DSC Communications Corp.,* 14 F.3d 1061, 1068 n. 3 (5th Cir.1994)).

Clearly, what is alleged in the complaint before us is limited to speculation and unsupported conclusion: that HCA's accounting methodology is prohibited (a fact that the plaintiff asserted, but never supported by reference to any law or regulation), that unidentified persons made claims for reimbursement based on the accounts on unspecified occasions and, as a result, that all such claims violate the Act. Just as clearly, the district court was correct in finding that these allegations failed to satisfy Rule 9(b). As the Eighth Circuit noted in a recent False Claims Act decision that, like this case, involved allegedly fraudulent Medicaid/Medicare billing, Rule 9(b) requires a *qui tam* plaintiff to do more than merely charge that the defendants engaged in fraudulent schemes that were "pervasive and wide-reaching in scope" and then "argue[ ] that the defendants must have submitted fraudulent claims" to the government. *United States ex rel. Joshi v. St. Luke's Hospital, Inc.,* 441 F.3d 552, 557 (8th

Cir.2006) (citing *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1013 (11th Cir.2005), as disallowing a complaint that alleged improper business practices but "failed to provide a factual basis to conclude fraudulent claims were ever actually submitted to the government in violation of the False Claims Act").

Moreover, the district court's Rule 9(b) determination was fully in conformity with existing Sixth Circuit precedent, notably our recent False Claims Act decision in *Yuhasz,* as reaffirmed in *United States ex rel. Bledsoe v. Community Health Systems, Inc.*, 342 F.3d 634 (6th Cir.2003). Like HCA, the defendant in *Yuhasz* was a government contractor-but in the aerospace rather than the health care industry. Yuhasz charged Brush Wellman with submitting reimbursement claims for the production of alloys that did not, in fact, meet government specifications. The complaint was replete with details concerning deficiencies in the defendant's manufacturing process but did not assert that any specific false claims had been submitted to the government. We held that "[t]he failure to identify specific parties, contracts, or fraudulent acts require[d] dismissal." 341 F.3d at 564. In doing so, we relied on the analysis in *Clausen,* as well as that in *United States ex rel. Walsh v. Eastman Kodak Co.*, 98 F.Supp.2d 141, 147 (D.Mass.2000), in which the court noted that the plaintiff had "set[ ] out a methodology by which the vendors might have produced false invoices, which in turn could have led to false claims," but dismissed the complaint for failure to comply with Rule 9(b) because it failed to "cit[e] a single false claim arising from an allegedly false invoice." *Id.* Like Yuhasz, plaintiff Sanderson has proved "unable to identify a specific claim submitted directly to the United States by [the defendant]," 341 F.3d at 564, and, like the complaint in *Yuhasz,* Sanderson's complaint was properly dismissed by the district court.

We conclude that the district court was likewise correct in determining that the complaint was not timely filed and did not state a cause of action on which relief could be granted, both grounds for dismissal under Rule 12(b)(6). Because the basis for the Rule 9(b) determination is so clearly indicated, however, we find it unnecessary to discuss the remaining issues raised under Rule 12(b)(6).

CONCLUSION

For the reasons set out above, we AFFIRM the judgment of the district court.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

No. 3:01-0580

[Filed September 28, 2004]

UNITED STATES OF AMERICA, ex rel. PHILIP SANDERSON,	)
Plaintiff,	)
v.	)
JUDGE HAYNES HCA - The Healthcare Company, Columbia Health Care Corporation, Hospital Corporation of America and HealthTrust, Inc.,	)
Defendants.	)

MEMORANDUM

Plaintiff, Philip Sanderson, filed this *qui tam* action against the Defendants, HCA, the Healthcare Company (now know as HCA, Inc.) And its predecessors, Columbia Health Care Corporation, Hospital Corporation of America, and

HealthTrust, Inc. (collectively, "HCA"). The United States decided not to participate in this action.

Sanderson, a former HCA employee who last worked at HCA approximately fifteen years ago, alleges that HCA violated the False Claims Act by submitting reimbursement claims to governmental health programs for the costs of its borrowings, and in so doing, allocated its debt so as to violate the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* In an earlier proceeding, HCA moved to dismiss the original complaint, contending, in sum, that the complaint failed to plead fraud with sufficient particularity, failed to state a claim upon which relief can be granted, and that Sanderson's were time-barred.[1] (Docket Entry No. 33). The Court denied HCA's motion to dismiss without prejudice, allowing Sanderson to amend his complaint. (Docket Entry No. 51). In addition, the Court allowed HCA to renew its motion upon the filing of an amended complaint, by incorporating its prior submissions for its earlier motion. *Id.* On February 26, 2004, Sanderson filed his First Amended Complaint. (Docket Entry No. 52).

Before the Court is the Defendants' Motion to Dismiss Plaintiff's First Amended Complaint (Docket Entry No. 55), founded upon the same grounds as in their earlier motion -- namely, that the First Amended Complaint that the complaint fails to plead fraud with sufficient particularity, Fed. R. Vic. P. 9(b); fails to state a claim upon which relief can be

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[1] HCA also moved to dismiss five counts in the initial complaint – common law causes of action of recovery for mistake, unjust enrichment, illegal profits, recoupment, and fraud -- on the grounds that Sanderson lacked standing. (Docket Entry No. 34, Defs.' Memorandum in Support of Motion to Dismiss, at 13). These counts are not included in Sanderson's First Amended Complaint.

granted, Fed. R. Civ. P. 12(b)(6); and that Sanderson's claims are barred by the six-year statute of limitations for the False Claims Act, 31 U.S.C. § 3731(b)(1). Sanderson responds that the First Amended Complaint successfully states a cause of action that is both sufficiently plead and timely.

For the reasons stated below, the Court concludes that the claims in the First Amended Complaint arising from actions that occurred prior to June 1995 are time-barred, and that the claims arising from the alleged actions have not been pleaded with sufficient specificity to state a claim for relief. Accordingly, the Court grants the Defendants' motion to dismiss.

A. Review of the Complaint[2]

In his First Amended Complaint, Sanderson alleges that from 1981-86, HCA borrowed "hundreds of millions of dollars" from financial institutions and issuing debt instruments to finance construction projects to erect new and renovate existing hospitals. (Docket Entry No. 52 at ¶¶ 60, 62).[3] HCA secured these debt instruments through it sown

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[2] Where, as here, there is an amended complaint, the Sixth Circuit has stated that the original complaint is rendered a nullity as the "'amended complaint supercedes the original complaint.'" *Klyce v. Ramirez*, 852 F.2d 568, No. 87-5176, 1988 WL 74155, at *3 (6th Cir. July 18, 1988) (unpublished opinion) (quoting *Frutz v. Standard Sec. Life Ins. Co.*, 676 F.2d 1356, 1358 (11th Cir. 1982)). All factual references and conclusions of law, therefore, are made with regard to the First Amended Complaint.

[3] Sanderson includes specific examples of the notes, bonds, and debt instruments, as reflected in sixteen handwritten entries in his "Analysis of Debt Allocation", dating from February 5, 1981 to

assets as "pooled funds", rather than through the assets of a specific hospital, so that "the allocation of interest expense were required to be allocated to the home office as a home office cost for purposes of the Medicare home office cost statement reporting requirement." *Id.* At ¶ 63. As a result, the "Medicare utilization rates for the home office were a weighted average of all of the Defendants['] . . . legal entities, including . . . entities for which there was no allowable cost or reimbursement,"and would thereby create "lower reimbursement rate[s] on reimbursable expenses allocated from the home office and contained in the home office cost statement[s] than it would if the debt and corresponding expenses were directly assigned to individual hospitals or facilities that had a higher utilization rate and . . . a correspondingly higher reimbursement rate." *Id.* At ¶ 64.

When submitting reimbursement claims to the Government (through Medicare, Medicaid, and the TRICARE/CHAMPUS program), however, HVA Sanderson alleges that HCA assigned "what were in actuality home office costs or pooled costs" to individual hospitals, thereby "falsely inflat[ing] the costs actually attributable to those facilities and the United States reimbursed [HCA] at rates significantly in excess of what would have been reimbursed in the absence of the direct assignment of debt and expense to the facilities and therefore, significantly in excess of what was permitted under Medicare and the other programs." *Id.* at ¶ 65. According to Sanderson, this "false inflation" has "resulted in annual overpayments by the United States due to the inflated yearly cost facility reports." *Id.* at ¶ 66. Sanderson alleges that "[t]he interest expense, based upon the direct assignment of debt to the facility, is ongoing and

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April 22, 1986. *Id.* At ¶ 61 & exh. 1.

continues until such time as the debt was fully retired, thereby resulting in continued overpayment until such time as the debt was fully paid or fully amortized, [resulting] in an inflated annual cost report for the facility for as many as 20 or even 30 years into the future and continues to this day." *Id.*

Additionally and alternatively, Sanderson claims that "upon retiring the pooled debt, [HCA] 'reassigned' debt to facilities with the highest utilization rate [leading to] cost reports [that] were illegally inflated to maximize earnings and return on reimbursement." *Id.* at ¶ 67. From December 1981 through August 1986, therefore the debt was assigned by HCA in such as a way to result in an overpayment of "nearly 13 million dollars in any given year." *Id.* at ¶ 68. Sanderson claims that as of 2001, HCA had "in excess of one billion dollars in long term debt." *Id.*

Sanderson left HCA in 1989, but contends that "upon information and belief, [HCA] either continued the direct assignment of debt or made a direct 'reassignment' of debt and corresponding debt expense to the same facilities or other facilities with greater utilization rates . . . ."[4] *Id.* At ¶ 69. In addition, HCA was allegedly "aware of [the] illegality . . . [because upon information and belief[,] HCA in reserving for legal contingencies, reserved an amount to cover the overcharges in the event the direct assignment of debt and interest was ever discussed by Medicare auditors. *Id.* at ¶ 70.

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[4] It is important to note that Sanderson refers in and attaches to his First Amended Complaint memoranda from HCA officials dated April 14, 1981, December 11, 1981, and March 8, 1983, which he contends demonstrate the alleged fraudulent reimbursement schemes. *Id.* at ¶ ¶ 71-73 & exhs. 2-4. Plaintiff neither refers to nor provides any specific evidence for such allegedly illegal activity for any date after April 22, 1986.

Based upon these facts, Sanderson alleges that HCA "submitted false and fraudulent claims, [conspired to submit false and fraudulent claims,] and fraudulently obtained payments from the United States in violation of the False Claims Act." *Id.* at ¶ ¶ 74, 77-88.

B. Conclusions of Law

"[A] complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the Plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 811 (1993). Consideration of a motion to dismiss requires the court accept the complaint's factual allegations as true and to construe the complaint liberally in favor of the plaintiff. *Perry v. Am. Tobacco Co., Inc.*, 324 F.3d 845, 848 (6th Cir. 2003). Despite such liberal construction, a court "need not accept as true legal conclusions or unwarranted factual references." *Morgan v. Church's Fried Chicken*, 829 F.2d 10, 12 (6th Cir. 1987) (internal quotation omitted). Indeed, "it is not. . . proper to assume that the [Plaintiff] can prove facts that it has not alleged or that the defendants have violated the . . . laws in ways that have not been alleged." *Assoc. Gen. Contractors v. Cal. State Council of Carpenters*, 459 U.S. 519, 526 (1983). Moreover, to survive a motion to dismiss under Rule 12 (b)(6), "the complaint must contain 'either direct or inferential allegations respecting all the material elements'" of the claim. *Tahfs v. Proctor*, 316 F.3d 584, 590 (6th Cir. 2003) (quoting *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 436 (6th Cir. 1988).

For a majority of civil actions, the complaint is sufficient if it satisfies the "notice" pleading requirements of the Federal Rules of Civil Procedure with a "short and plain statement of

the claim showing the pleader is entitled to relief," because generally "[n]o technical forms of pleadings or motions are required." Fed. R. Civ. P. 8(a)(2), (e)(1). In certain situations, however, the Rules imposes heightened "special pleading" requirements. Fed. R. Civ. P. 9. Failure to specially plead where required can result in a dismissal of the complaint. *See, e.g., Hoover v. Langston Equip. Assocs., Inc.*, 958 F.2d 742, 744 (6th Cir. 1992) (holding, under Rule 9(f), where factual allegations about time are lacking in the complaint, then the Court can grant a motion to dismiss). Two such requirements are pertinent to this case. The first is the requirement that "all averments of . . .the circumstances constituting fraud . . . shall be stated with particularity." Fed. R. Civ. P. 9(b). This requirement is "designed to allow the District Court to distinguish valid from invalid claims in . . . and to terminate needless litigation early in the proceedings." *Blount Fin. Servs. v. Walter E. Heller & Co.*, 819 F.2d 151, 153 (6th Cir. 1987). It is also intended "to provide a defendant fair notice of the substance of a plaintiff's claim in order that the defendant may prepare a responsive pleading." *Am. Town Center v. Hall 83 Assocs.*, 912 F.2d 104, 109 (6th Cir. 1990). In the Sixth Circuit, to satisfy Rule 9(b), "a plaintiff must, at a minimum allege the time, place and contents of the [alleged] misrepresentations . . . ." *Id.* (Internal quotations omitted). Second, Rule 9(f) requires that "[f]or the purposes of testing the sufficiency of a pleading, averments of time and place are material and shall be considered like all other averments of material matter."

Of the Defendants' contention, the Court addresses first their statute of limitations argument that, if true, would moot consideration of the other contentions. An action arising under the False Claims Act "may not be brought more than six years after the date on which the violation is alleged to have been committed." 31 U.S.C. § 3731(b).

Sanderson's original complaint cited HCA's allegedly fraudulent activities that occurred "[b]etween 1981 and 1986." (Docket Entry No. 1, Compl., at ¶ 60). The original complaint, like the First Amended Complaint, makes reference and has annexed thereto specific instances and documents evincing the allegedly fraudulent practices of HCA. *Id.* At ¶ ¶ 61-64 & exhs. 1-4. In response to HCA's first motion to dismiss, Sanderson's First Amended Complaint restates the specific instances of allegedly fraudulent conduct from 1981 to 1986 (Docket Entry No. 52 at ¶ ¶ 60, 71-73 & exhs. 1-4), but alleges only that based "upon information and belief" such allegedly unlawful conduct is ongoing. (Docket Entry No. 52 at ¶ ¶ 69-70).

The Court concludes that Plaintiff's First Amended Complaint does not set forth specific allegations of fraudulent conduct in violation of the False Claims Act within six years of the filing date of this action. Any specific reference to allegedly fraudulent conduct occurred prior to the statutory period. To the extent that Sanderson alleges that such activity has occurred since June 1995, he merely does so based "upon information and belief" the conduct is ongoing; such a vague and cursory contention does not rise to the heightened level of the requisite specificity under Rule 9(b). Plaintiff was on notice that the statute of limitations was at issue. The Court deems the failure to allege specific acts within the statutory period as failing to allege a material statement of Plaintiff's claims.

In any event, even if the Court were to look beyond the timelines and heightened pleading defects in Plaintiff's First Amended Complaint, the Court finds that the Complaint fails to state a cause of action upon which relief can be granted. A private litigant who brings a *qui tam* action on behalf of the Government under the False Claims Act must show that the

defendant, *inter alia*: "(1) knowingly presents, or causes to be presented, to [the Government] a false or fraudulent claim or approval; (2) knowingly makes, uses, or cases to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; [or] (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid . . ." 31 U.S.C. § 3729(a). For purposes of the False Claims Act, a person acts "knowingly" when he: "(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth of falsity of the information, and no proof of specific intent to defraud is required." 31 U.S.C. § 3729(b). Plaintiff fails to describe in his First Amended Complaint any fraudulent claims made during the statutory period. Moreover, Plaintiff has failed to identify any applicable rule or regulation that was violated by HCA since 1995. Because Plaintiff has not alleged sufficiently each element of his claims under the False Claims Act, "it appears beyond doubt that the Plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Hartford Fire Ins. Co.*, 509 U.S. at 811. Were the Court to reach this issue, therefore, it would find that Plaintiff has filed to state a claim upon which relief could be granted and would dismiss the action under Fed. R. Civ. P. 12(b)(6).

Thus, the Defendants' motion to dismiss is **GRANTED**.

The action is **DISMISSED** with prejudice.

This is the Final Order in this action.

It is so **ORDERED**.

ENTERED this the 28th day of September, 2004.

/s/ Wm. Joseph Haynes, Jr.
WILLIAM J. HAYNES, JR.
United States District Judge

APPENDIX C

STATUTORY PROVISIONS AND RULES

31 U.S.C.§ 3731(b)

False claims procedure

(b) A civil action under section 3730 may not be brought--

(1) more than 6 years after the date on which the violation of section 3729 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

Federal Rule of Civil Procedure 9(b)

Pleading Special Matters

(b) **Fraud, Mistake, Condition of the Mind.** In all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.